Ministry of Health, Government of Southern Sudan

Basic Package of Health Services For Southern Sudan

Second draft for further review – March 2006

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Special thanks to all the senior staff, especially Dr. Samson Baba, Dr. Nathan Atem and Dr. John Rumunu and Dr. Olivia Lomoro at the Ministry of Health, Government of Southern Sudan for their technical input and cooperation in creation of this document. Profound thanks also goes to the Health and Nutrition Consultative Group whose constructive feed back have contributed and shaped the content of these documents based on realities on ground.

Please, note that this is a draft document under further review and development.

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The Under Secretary,
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ACRONYMS

ABC	Abstinence, Be faithful, Condom use
ARI	Acute Respiratory Infection
ARV	Anti Retroviral therapy (against HIV)
CHD	County Health Department
CHW	Community Health Worker
CMOH	County Medical Officer of Health
CPT	Cotrimoxazole Prophylactic Treatment
CTC	Community-based Therapeutic Care
DOTS	Directly Observed Treatment – short course
EmOC	Emergency Obstetric Care
EWARN	Early Warning Alert and Response Network
FGM	Female Genital Mutilation
GAM	Global Acute Malnutrition
GAVI	Global Alliance for Vaccines and Immunisation
GFATM	Global Fund against AIDS, Tuberculosis and Malaria
GOSS	Government of Southern Sudan
HHP	Home Health Promoter
HNCG	Health and Nutrition Consultative Group
IMCI	Integrated Management of Childhood Illnesses
ITN	Insecticide Treated Net
IEC	Information, Education and Communication
IECHC	Integrated Essential Child Health Care
JAM	Joint Assessment Mission
MCH	Mother and Child Health
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health (GOSS)
MUAC	Mid Upper Arm Circumference
NID	National Immunisation Day
OPD	Outpatient Department
PMTCT	Prevention of Mother to Child Transmission (of HIV)
RUTF	Ready to Use Therapeutic Food
SoH	Secretariat of Health (predecessor of MoH)
SSRC	Sudan Relief and Rehabilitation Commission
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
VCT	Voluntary Counselling and Testing

INTRODUCTION

Southern Sudan has suffered until very recently from civil war since independence in 1956, with a brief respite in the latter 1970s. Southern Sudan covers an area of approx. 640'000 kilometres divided into ten states[1] with over 90 counties. The population is estimated at 7.8 – 10 million and expected to increase to up to 12 m until 2010, owing to returnees and natural growth. Southern Sudan is one of the poorest regions in the world, although prospects of oil revenue promise future economic improvement. Most socio-economic and health indicators are below the level of the rest of Sudan. Indicators of primary school enrolment and completion as well as adult literacy are among the worst world-wide. Infant mortality rate is estimated at 150/1000 live births and under-five mortality rate at 250/1000 live births. Routine immunisation coverage is well below 10%[2] and total fertility rate is estimated to be higher[3] than average in Sub-Saharan Africa. Gender-related health risks are common; the proportion of births attended by skilled health staff is also among the lowest in the world. A wide range of 'tropical' diseases that are controlled elsewhere are endemic in Southern Sudan; many of these are also so-called 'neglected diseases'. Despite the end of widespread famine, malnutrition among children remains endemic. With few exceptions, population density is low, which remains an obstacle to both service provision and access to health care.

NGOs have played an important role in the delivery of health services in Southern Sudan; UNICEF, USAID, WFP, and WHO has played a major role among the UN agencies. Interventions were often disjointed and inefficient though, and the focus on first-level health services and disease specific programmes – typical for humanitarian action - has overshadowed attention to first-level referral hospitals and capacity building for mid-level and higher professionals. Overall access to health care remains minimal (user rate has been estimated as low as 0.2 contacts per person per year). Shortage of skilled human resources has been – and is – one of the major limiting factors to the provision of care, and the care provided is often poor. Traditional medicine is practiced either out of conviction or because no other means of care are available. The private for-profit sector is minimal and not expected to play a big role in the near future apart from a small number of urban centres.

The World Bank leads a Multi-Donor Trust Fund that will channel resources to the health sector for the coming years. The expected flow of external funds for the health sector – expected to be limited in time – can be put to better use if contributing to build one health system instead of continuing 'projectism'. In this perspective the MoH-GoSS advocates an integration of the existing vertical programs in the resource pool and in the management structures of the mainstream health system. The definition of the Basic Package of Health Services (BPHS) is guided by the values recently defined in the MoH Policy Paper, namely: right to health, equity, pro-poor, community ownership and good governance. The main criteria for the choice of services were the ones that would have the greatest impact on the health of the population, that would be equally accessible to the largest possible part of the population and be affordable on the short run and sustainable on the long run.

[1] Western Equatoria, Bahr el Jabel, Eastern Equatoria, Northern Bahr el Ghazal, Western Bahr el Ghazal, Lakes, Warrap, Jonglei, Unity and Upper Nile
[2] USAID (2003)
[3] 5.9 (JAM), 6.7 (JIS/Sudan Health Transformation Project)

The BPHS for Southern Sudan includes curative, preventative, managerial and health promotion activities, whether provided by the Ministry of Health, Government of Southern Sudan (MoH-GoSS), State Ministries of Health (SMoH) or contracted out to implementing partners (Faith-Based Organisations or NGOs). In the latter case, the capacity of the MoH-GoSS and the State Ministries of Health for tendering and supervision has to be strengthened in order to allow it to fulfil its responsibilities. Whoever implements the BPHS will have the obligation – and be given the funds - to implement the full package for a defined geographical area. The importance of mechanisms of monitoring and accountability at all levels cannot be stressed enough.

The BPHS attempts to be valid for the immediate future and until 2011. It has therefore to be realistic on the one hand – especially with regard to available skilled human resources – and, on the other hand, define a level to aspire to. Getting from here to there will happen by staging it in two ways, and both ways will be applied at the same time: first, by increasing the geographical coverage of the – ideally full – BPHS, secondly (as synchronisation of production of the various resources needed will be difficult) by introducing its elements gradually; facility-based deliveries, for instance, will be introduced only once a Community Midwife is available and ARVs only once uninterrupted supply can be guaranteed (and mostly in state hospitals). A strong warning is indicated for both kinds of staging: the introduction and perpetuation of substandard health services will lead to low staff morale and to under-use by the population. Once such a vicious circle has set in, it will be very difficult to break. In case of contracting-out, the staging has to be specified in the contract between the three parties (implementing partner, MoH-GoSS and donor). Because of the large geographic diversity in terms of existing health structures and human resource availability the implementation arrangements of the BPHS might differ initially by region. The specific details, e.g. the timing of the stepped approach to reach the full BPHS package, will therefore be covered through individual agreements between the MoH-GoSS and the implementing organization. These agreements will take into account the actual situation per region and the realistic targets to be achieved within the agreement period. The availability of qualified man-power to deliver the BPHS is the single most important factor that will limit the expansion of its coverage and the implementation of all its components.

The first version of the BPHS is expected to have a life-span of 3 years, for the strategy period 2006-2008; work on a revised version for the second strategy period 2009-2011 should start in the beginning of 2008. This document is the result of a one-month bilateral consultation process with key stakeholders and literature research. After first analysis by the MoH-GoSS, it was submitted to the Health and Nutrition Consultative Group. The first draft of the document was discussed in a consultative workshop in Juba in February 2006, whose outcome was discussed in the Health and Nutrition Consultative Group (HNCG). The second draft was developed incorporating the recommendations received by sector stakeholders. Considerations resulting from the subsequent costing exercise will then have to be taken into account for the final version.

The BPHS includes five levels of facilities/services:

1. Community-based health activities
2. Primary Health Care Unit (PHCU)
3. Primary Health Care Centre (PHCC)
4. County Hospital (CH)

5. County Health Department (CH)

The BPHS does not intend to address higher levels of the health system, such as State Hospitals, or National reference laboratories etc.

The service profiles at the five levels are described (which should be binding for any service provider) as well as - only in indicative fashion (and therefore to be intended largely as a recommendation) - the resources needed: infrastructure, equipment, essential drug supply and human resources. The BPHS document also covers a number of specific sectors more in depth, such as reproductive health, child health and immunisation, communicable diseases, water and sanitation, and nutrition. The main document presents the BPHS service profile in very succinct form (section 1), presents key elements of sector activities (section 2) and gives a summary overview of key elements in table form (section 3). The document with annexes presents details with regard to service profile (annex I) resources (annex II), sectors (III), contacts made (IV) and references used (V).

The first draft BPHS was elaborated by WHO during the month of November 2005, funded by the Italian co-operation through the First Steps project of the UN work plan 2005. The author of this draft expresses his warmest thanks to the MoH and to all others who have contributed: WHO colleagues, staff members of UN agencies and NGOs, and individual consultants. The second draft was prepared after the consultative workshop held in Feb 2006. The inputs received by the participants to the workshop proved very valuable and constructive to the finalization of the document.

1. SERVICE PROFILE

Southern Sudan cannot go back to simply running the health services functioning before the war. The necessity to define nearly from scratch profiles and coverage of health services is an opportunity for effective planning and equitable distribution. Intermediate targets for 2011 with regard to the coverage of the population with health services have been set and adopted in the Health Sector Recovery Strategy and by the JAM reports. The BPHS is based on these figures, as illustrated in table 1.

Table 1: Health facilities per population and total number of health facilities according to the Health Sector Recovery Strategy.

Type of health service	**Facilities per population** [4]	**Total no. of facilities**[5]
Primary Health Care Unit	1 / 15'000	800
Primary Health Care Centre	1 / 50'000	240
County Hospital	1 / 300'000	40

Although these figures may still change according to the process of formulation of a health care network development plan and regional variations may apply according to the baseline situation, they do provide a useful framework of reference for a discussion on the BPHS. In any case the service profile levels required and the inputs recommended by the BPHS should not vary if these population-to-health-facility ratios were to change.

The availability of financial resources for the MoH will be a key determinant for the staging of over-all coverage. Regional variations will have to be allowed for, according to criteria of population density, geographical accessibility and resource availability.

Shortage of skilled human resources is – and will remain - one of the main limiting factors for the provision of health services in Southern Sudan, which requires an enormous investment in training. On the short run, already, a common salary scale including hardship allowances needs to be established as integral part of the BPHS.

The BPHS should not be an obstacle to innovation. Mere efficacy of a strategy, however, should not allow adopting it for the whole country if it was implemented in near-ideal conditions – especially on a small scale by an international NGO with considerable resources. Models of health care provision that have not been sufficiently tested in Southern Sudan or comparable circumstances (such as mobile Primary Health Care Units) should therefore be piloted under conditions and with means with which the Ministries of Health will have to operate, before implementing them in a large scale.

[4]SPLM (2004) Laying the grounds for the recovery of the health sector in a post-conflict Southern Sudan. SPLM Secretariat. 2nd Draft, March 17, 2004

[5] Assuming a population growing to a maximum of 12 million until 2011

1.1 COMMUNITY-BASED HEALTH ACTIVITIES

(DETAILED SERVICE PROFILE: ANNEX I.1.)

Although the Government of Southern Sudan, through the Ministry of Health and State Ministries will be paying staff salaries, it is important, however, that certain curative and especially preventative health activities are carried into and supported by the community. The BPHS foresees co-operation with Health Committees and a network of Home Health Promoters, which are to be supported by the State Ministries of Health, in collaboration with the Ministry of Health, Government of Southern Sudan. The following tasks descriptions are ambitious and are not liable to be attained everywhere. However, if an implementing partner wishes to invest in a community that strives at empowerment, guidelines are to be given in the BPHS.

1.1.1. Health Committees

The Health Committee consists of elected community members. Care must be taken that these are representative of the whole community with regard to gender, religion, ethnicity, occupation and geographical origin. Among its key functions are:

- Acting as a custodian of the liaison between the SMoH, the service provider and the community
- Facilitating and encouraging community-based health development initiatives
- Identification and proposal to the CHD of candidates to be trained as CHWs
- Support and supervision of the local health services (PHCU/Cs) through:
    - Mobilisation of the community in supporting PHCU/C infrastructure and maintenance
    - Management of the cost-sharing / revolving drug fund schemes (if applicable)
    - Overseeing drug management

1.1.2. Home Health Promoters

Home Health Promoters (HHPs) are elected by the Health Committee and trained by the CHD and PHCU/Cs. Literacy is an advantage, but not mandatory. HHPs are not intended to be full-time professionals of the health system and as such receive no salary, but are motivated through other material and non-material incentives. HHPs should be residents in the community they serve and committed to serve all residents without distinction. Their key functions include:

- Health promotion (IEC, social marketing of condoms and Water-Guard)
- Active case finding and referral
- Mortality surveillance

In geographically very isolated areas, Integrated Essential Child Health Care (IECHC) may be implemented, provided that the implementing partner has sufficient capacity for training and supervision. In many cases, however, this strategy will be self-defeating; isolated areas are less likely to offer suitable candidates for training and are difficult to reach for supervision.

Conditions allowing, HHPs would then also carry out the following IECHC activities for children under five:

- Treatment and guidance for children with diarrhoea, ARI and fever, with ORS/zinc, amoxicillin and ACT, respectively
- Referral of sick children to PHCU/C

This list of tasks attributed to this cadre is intended to be comprehensive, and not necessarily it is to be implemented in full by each HHP: for instance some might be involved in social marketing of preventive commodities only, others in community based IECHC activities only, others in peer education on HIV and STDs only etc. The HHPs will be supported, supervised and coordinated by full-time salaried personnel of the PHCUs.

*1.1.3 Traditional birth attendants (TBAs)_*

Although investment directed at reducing maternal mortality will be made in training midwives and not in training Traditional Birth Attendants (TBAs), co-operation with already trained TBAs can be continued until the uptake of facility-based deliveries, itself conditioned by staffing PHCU/Cs with Community Midwives. The BPHS does not support the training of new TBAs. Organizations that wish to continue training TBAs should do so with their own funding and demonstrating that at the same time they are investing in the training of midwives. TBAs can continue being supported as other HHPs in roles other than the deliveries, such as IEC activities, iron-folic supplementation, IPT etc.

1.2 PRIMARY HEALTH CARE UNIT

(DETAILED SERVICE PROFILE: ANNEX I.2.)

Primary Health Care Units (PHCUs) are first-line health facilities functioning mostly in traditional buildings. One PHCU covers a population of roughly 15’000. Three health staff - two Community Health Workers and a Mother and Child Health Worker (to be replaced by a Community Midwife) - provide basic preventive and curative services. One of the CHWs is primarily in charge of the curative activities and is therefore based in the PHCU, while the second is responsible for overseeing and coordinating the community based activities implemented in collaboration with the network of HHPs. In a long term perspective the CHW in charge of the curative aspects of the PHCUs should be phased out and replaced by a clinical officer (CO), however this option is not realistic for the first version of the BPHS and will be considered again when revising the BPHS for the following triennium (2009-2011). The choice of drugs does not include injectables or IV fluids.

The implementation of mobile PHCUs - supposed to provide the same services with the same resources to nomadic and isolated populations – is to be piloted. The cost implications of such mobile units, however, do not warrant the adoption of this strategy on a vast scale.

Key activities of a PHCU are:

- Preventive care and health promotion (EPI and IEC, see annexes III.2. and III.5.)
- Antenatal care, normal deliveries and family planning (see annex III.1.), once trained staff is available
- Curative care for common and uncomplicated diseases
- Case-finding and treatment of chronic diseases diagnosed at higher level
- Referral to PHCC or CH for complementary exams or treatment, if necessary
- First aid for trauma, stabilisation and referral
- Home treatment and outpatient care for moderate acute malnutrition, follow-up patients with severe acute malnutrition (see annex III.4.)
- Training activities (of HHPs)
- Administrative and support activities (HMIS, maintaining registers and, if applicable, book-keeping)

1.3 Primary Health Care Centre

(Detailed service profile: annex I.3.)

One Primary Health Care Centre (PHCC) covers a population of roughly 50'000. It offers a wider range of services than a PHCU, notably laboratory diagnostics, an observation ward (which may include treatment of simple cases) and 24-hour basic Emergency Obstetric Care. The PHCC is staffed with a number of qualified health professionals, including Clinical Officers (COs) and Nurse Midwives. It also disposes of a wider range of drugs than PHCUs and can altogether handle more complicated cases.

Key activities of a PHCC are:

- Preventive care and health promotion (including fixed EPI and IEC, see annexes III.2. and III.5)
- Delivery Care (24-hour basic Emergency Obstetric Care, see annex III.1.):
    - Antenatal Care
    - Normal and assisted deliveries (vacuum extraction)
    - Non-surgical management of obstetric complications (basic EmOC, e.g. manual placenta removal, post-abortion manual vacuum aspiration)
    - Family Planning
- Curative care (including IM injections and IV lines for IV fluids and antibiotics)
- Home treatment and outpatient care for moderate and severe acute malnutrition; stabilisation care for severe acute malnutrition (see annex III.4.)
- First aid for emergency conditions and referral
- Small surgery (incl. first aid for trauma, stabilisation and referral)
- Dental care (on fixed days by dental technician from County Hospital, once available)
- TB diagnosis and treatment (DOTS)

- Laboratory examinations (see annexes I.3. and II.2.1.)
- Observation, with 10-20 beds
- Training (for PHCU staff)
- Health Management Information System
- Administrative and support activities (e.g. register keeping, drug management and maintenance and, if applicable, book-keeping)

1.4 County Hospital (detailed service profile: annex I.4.)

The County Hospital (CH) is the first-line referral hospital, with 80-100 beds. According to the coverage planned (roughly one CH per 300'000 population), there will actually be one CH per 2-3 countries, in the near future[6].

In the CH, patients are diagnosed, treated, referred back to the PHCU/Cs and also referred up to state and tertiary hospitals once these are up and running. For the time being, however, it is important to keep in mind that the large majority of patients will have to be treated at the CH and not in a higher level hospital.

The outpatient department (OPD) of the CH functions exactly like a PHCC to serve the population in the catchment area, and is staffed and equipped like one, with the exception of EmOC, stabilisation care for malnutrition and the laboratory, for which it relies on the hospital services. The CH provides basic curative care in the areas of gynaecology/obstetrics, surgery, internal medicine and paediatrics. Focus will be on the first of these: 24-hour comprehensive EmOC. Beyond curative care, like the other health services, the CH participates in training, epidemiological surveillance and health promotion activities. Special attention will also be given to managerial and administrative structures - including a Hospital Board – and processes

The key activities of the County Hospital are:

- Curative services
    - Gynaecology and 24-hour comprehensive EmOC (see annex III.1.)
    - Surgery (emergency surgery and basic elective surgery)
    - Internal medicine (incl. TB and other communicable diseases, see annex III.3.)
    - Paediatrics (including stabilisation care for malnutrition)
    - Emergency services open 24 hours
    - Safe blood transfusion
    - Physiotherapy (once available)
- Outpatient service (same as PHCC, incl. EPI and, if available, dental care)
- Diagnostic services
    - Laboratory (see annexes I.4. and II.2.1. for details)
    - Ultrasonography (if available)
    - X-ray (exceptionally)
- Management and administration

[6] And another name might be chosen

    - Supervision of clinical services and resource use
    - Human Resources management
    - Health Management Information System
    - Financial management
    - Procurement and storage
    - Maintenance and repair
- Support services
    - Sterilisation
    - Kitchen
    - Laundry
    - Waste management
    - Communication and transportation

1.5 County Health Department

(Detailed service profile: annex I.5.)

The County Medical Officer of Health (CMOH) as the head of the County Health Department (CHD) guarantees the implementation of the health policy, co-ordinates with other authorities and actors and supervises specific areas, such as:

- Health promotion
- Curative services
- HMIS (routine and early warning system)
- EPI
- Pharmaceuticals and medical supplies
- HR management
- Administration and Finance

In view of the shortcomings of skilled human resources, many of these functions may be carried out initially by an implementing partner to whom the BPHS is contracted out or by a separate partner charged with the responsibility of building the capacity of the CHDs, in case the MoH decides that the possibility of conflict of interest warrants a separation of the roles of service delivery and coordination and oversight of the same. Whichever option is chosen, it is important, however, that these functions are located at the CHD and not in the NGO/FBO partner's office and that investment in infrastructure and capacity building takes place over the years.

Owing to efficiency considerations, it is proposed that a CHD manages the health services of 2-3 counties, following the division by placement of County Hospitals. With regard to decision-making, a consensus between a potential implementing partner and the CHD has to be sought; key decisions (e.g. location of health facilities and staff appointments) have to be approved by the SMoH and MoH-GoSS.

The tables in the next chapter provide a synopsis over the service profile per level and selected specialised sectors.

2. OVERVIEW OF FACILITIES, INTERVENTIONS AND SERVICES PROVIDED

The following tables are not exhaustive, but provide an overview of the BPHS at one glance by listing key elements at each level and for the main sectors.

2.1 General overview of key facilities, interventions and services

Facilities, interventions, services provided	**HHP**	**PHCU**	**PHCC**	**CH**	**CHD**
Preventive care and health promotion					
Interventions for endemic, 'forgotten' diseases					
Health Management Information System					
Training					
Maternal Health					
Antenatal Care and normal deliveries					
Basic EmOC services 24 hs					
Comprehensive EmOC services 24 hs					
EPI					
Outreach EPI					
Outreach EPI in static facilities					
Fixed EPI					
General Curative Care					
Integrated Essential Child Health Care					
Curative outpatient care					
Supervision of curative care					
First aid and referral					
Small surgery					
Observation					
Stabilisation care for malnourished children					
Inpatient care (incl. surgery)					
Safe blood transfusion					
Dental care			(visit)		
Physiotherapy					
Basic specialised care (ENT, eye, mental)					
HIV/AIDS					
VCT and PMTCT					
Diagnostics					
Laboratory examinations					
Blood transfusion					
Ultrasonography					
x-ray examination (exceptionally)					
Kitchen, laundry					

2.2 Primary Health Care Unit Summary

<table>
<tr><td colspan="5">Catchment area: 15’000 population</td></tr>
<tr><td colspan="2">Service profile</td><td>Human Resources</td><td>Facilities</td><td>Equipment</td></tr>
<tr><td rowspan="4">Reproductive health</td><td>IEC on sexual health and HIV</td><td rowspan="11"><u>Technical</u> [3]

Community Health Worker [2] (1 for facility-based curative activities, 1 for community based promotive activities)

Maternal and Child Health Worker [1] replaced by Community Midwife

<u>Support</u> [3]

Janitor (guard/cleaner) [1-exceptionally 2]

Dispenser [1] (Although this is classified as a non-technical staff, this cadre should undergo training according to the 2 weeks module in the CHW curriculum relative to drug management)

Receptionist [1]

<u>Total staff</u>: [6] It is recommended that the person in charge of the PHCU should be the most senior in terms of training undertaken</td><td rowspan="11">Consultation Rooms (2)

Delivery room

Dispensing / Store

Waiting area

Latrine

Water store</td><td rowspan="11">Examination tables

Delivery table

Fetoscope

Stethoscope

Sphygmo-manometer

Thermometer

Dressing set

Baby scale

Adult scale

Bicycle</td></tr>
<tr><td>Antenatal care</td></tr>
<tr><td>Normal deliveries</td></tr>
<tr><td>Family planning: condoms and oral</td></tr>
<tr><td rowspan="3">Child health</td><td>Outreach EPI</td></tr>
<tr><td>Outreach EPI in static facility</td></tr>
<tr><td>Treatment of children with diarrhoea, malaria, ARI and anaemia with oral drugs, based on IMCI algorithm</td></tr>
<tr><td rowspan="3">Communi-cable diseases</td><td>Clinical management according to national protocols (incl. DOTS)</td></tr>
<tr><td>Rapid test for malaria</td></tr>
<tr><td>CPT and multivitamins for PLWHA</td></tr>
<tr><td rowspan="3">Nutrition</td><td>Growth monitoring (to be defined by MoH-GoSS Ex Board)</td></tr>
<tr><td>Diagnosis and home treatment for moderate acute malnutrition</td></tr>
<tr><td>Follow-up cases of severe acute malnutrition (diagnosed and stabilized at PHCC level)</td></tr>
</table>

2.3 Primary Health Care Centre Summary

<table>
<tr><td colspan="4">Catchment area: 50’000 population</td></tr>
<tr><td colspan="2">Service profile</td><td>Human. Resources</td><td>Facilities[7]</td><td>Equipment</td></tr>
<tr><td rowspan="6">Reproductive health

(24-hour basic EmOC services)</td><td>IEC on sexual health</td><td rowspan="11"><u>Technical</u> [11]

Clinical Officer [1]

RN/Certified Nurse [1]

CHW[8] [3]

MCHW [2] replaced by: Community Midwife

(Nurse-) Midwife [1]
Lab assistant[1]
Public Health Technician [1]
Pharmacist technician [1]
Dental technician[9] [1]

<u>Support</u> [5]
Record keeper / Book-keeper [1]
Receptionist [1]
Cleaner [1]
Guards [2]
<u>Total staff</u>: [16]</td><td rowspan="11">Reception/ Registration/ Cashier / Communic.

Staff Office/ on duty

Consultation rooms

VCT room

EPI /Growth monitoring

ANC room

Maternity

Dressing/ injection

Observation ward (10-20 beds)

Stabilisation for malnutrition

Sterilisation
Laboratory
Pharmacy
Store
Lightning
Borehole</td><td rowspan="11">Stethoscopes
Otoscope

Sphygmo-manometer,
Thermometer

Baby scale
Adult scale
Beds, bedding

Delivery table
Fetoscope
Delivery equipment for basic EmOC

Small surgery equipment

Manual resuscitation equipment

Autoclave

Cold chain equipment

Laboratory equipment

Refrigerator
Communication equipment
Bicycles</td></tr>
<tr><td>Antenatal Care</td></tr>
<tr><td>VCT and PMTCT</td></tr>
<tr><td>Normal deliveries</td></tr>
<tr><td>Non-surgical management of obstetric complications</td></tr>
<tr><td>Family planning: condoms, oral, depot</td></tr>
<tr><td rowspan="2">Child Health and EPI</td><td>Fixed and outreach EPI</td></tr>
<tr><td>Treatment of children with diarrhoea, malaria, ARI, anaemia with oral and injectable drugs, based on IMCI algorithm</td></tr>
<tr><td rowspan="3">Communi-cable diseases</td><td>Case management according to national protocols</td></tr>
<tr><td>Laboratory diagnosis for malaria, TB, HIV and others</td></tr>
<tr><td>VCT and PMTCT</td></tr>
<tr><td rowspan="3">Nutrition</td><td>Growth monitoring</td></tr>
<tr><td>Home treatment of moderate malnutrition</td></tr>
<tr><td>Diagnosis/ stabilization of severe malnutrition</td></tr>
</table>

[7] Additional space is needed if housing of staff posted from elsewhere is considered
[8] Alternative: 2 CHWs and one vaccinator
[9] Once available, visiting on fixed days from County Hospital

2.4 County Hospital Summary

<table>
<tr><td colspan="5">Catchment area: 300’000 population</td></tr>
<tr><td colspan="2">Service profile (80-100 beds)</td><td>Human Resources</td><td>Facilities[10]</td><td>Equipment</td></tr>
<tr><td rowspan="3">Gynaecology / obstetrics

(24-hour comprehensive EmOC)</td><td>Normal/ complicated deliveries, including surgical interventions (esp. C-sections)</td><td rowspan="11"><u>Technical</u> [76]

Medical Dr[11] [2]

Clinical Officers [4] (Specialised COs)

Nurses (RN, CN/aux) [51]

(Nurse-)Midwife[1] MCHW replaced by Community Midwife [5]

OPD CHW [3]

Physiotherapist [1]

Anaesth. Nurse [2]

Scrub Nurse [2]

Lab assistant [1]

Lab technician [1] (X-ray technician)

Dent. technician [1]

Pharmacist technician [2]</td><td rowspan="11">Emergency ward

OPD

Operating Theatres

Maternity

Four wards (one per specialty)

Stabilisation for malnutrition

TB ward

Laboratory

Archives

Laundry

Store

Workshop

Kitchen

Garage

Incinerator</td><td rowspan="11">Beds, bedding

Delivery table

Delivery instruments

Vacuum extractor

OT table

OT lamps

Surgical instruments

Autoclaves

Anaesthetic equipment

Ultrasound machine (if possible)

(exceptional: x-ray)

Laboratory equipment

Refrigerator

Ambulance</td></tr>
<tr><td>Blood transfusions</td></tr>
<tr><td>Gynaecological surgery</td></tr>
<tr><td rowspan="3">General surgery</td><td>Emergency surgery</td></tr>
<tr><td>Basic elective surgery</td></tr>
<tr><td>Anaesthesia</td></tr>
<tr><td>Internal medicine</td><td>Case management of acute and chronic conditions (incl. communicable dis.)</td></tr>
<tr><td rowspan="3">Paediatrics</td><td>Case management of acute and chronic conditions</td></tr>
<tr><td>Management of neonatal complications</td></tr>
<tr><td>Stabilisation care for malnutrition with Complications</td></tr>
<tr><td>24-hour Emergency</td><td></td></tr>
<tr><td rowspan="3">Diagnostics</td><td>Laboratory</td></tr>
<tr><td>Ultrasonography</td></tr>
<tr><td>X-ray (exceptional)</td></tr>
</table>

[10] Additional space is needed if day care for children of staff and housing of staff posted from elsewhere is considered

[11] One of them doubling as hospital director

[12] For 100 beds, full occupancy

		Support [31] Administrator [1] Book-keeper/ [1] Maternity Receptionist [2] Clerk/ record keeper [3] Store keeper [1] Cleaners [12] (Kitchen staff) Laundry staff [2] Maintenance/ Labourer [2] Driver [1] Guards [6] Total staff[12]: [107]	Mortuary	Communi-cation equipment Generator
OPD[13]	Basic ENT, eye and mental health care (where available) Basic dental care			
Management and admin				
Support services	Sterilisation			
	Laundry			
	Kitchen			
	Waste management			
	Communic./ trsp.			

[13] The outpatient department (OPD) of the CH functions exactly like a PHCC; the OPD functions are therefore not repeated here and we refer to table 2.3 above: PHCC Summary. Human Resources calculated accordingly

2.5 Equipment

Facilities, interventions, services provided	HHP	PHCU	PHCC	CH	CHD
General					
Computers and internet connectivity					
Communication equipment					
Car (to be defined by MoH Ex. Board)					
Ambulance					
Motorbike					
Bicycle					
Furniture					
Tables, desks					
Examination beds					
Beds, mattresses, sheets					
Delivery tables					
Surgical instruments and sterilisation equipment					
Dressing sets					
Instruments for small surgery					
OT tables, surgical instrument sets					
Anaesthesia equipment					
Autoclave					
Diagnostics					
Sphygmomanometer/stethoscope/thermometer					
Otoscope					
Microscope					
Ultrasound machine					
X-ray machine (exceptionally)					
Others					
Refrigerator			(EPI)		(EPI)
Generator					

2.6 Human Resources

Facilities, interventions, services provided	**Community**	**PHCU**	**PHCC**	**CH**	**CHD**
Volunteers					
Home Health Promoters					
Health Committees members					
Trained TBAs					
Technical staff					
Community Health Worker					
Mother and Child Health Worker / Community Midwife					
Laboratory Assistant					
Laboratory technician					
x-ray technician (exceptionally)					
Nurse Midwife					
Certified Nurse / Auxiliary Nurse					
Registered Nurse					
Public Health Technician					
Specialised CO (e.g.ENT)[14]					
Clinical Officer / Medical Assistant					
Medical doctor					
Clerical and auxiliary staff (several functions may be combined in one person)					
Cleaner / guard					
Clerk/cashier/record keeper/receptionist					
Kitchen and laundry staff					
Pharmacist (technician)/storekeeper					
Administrator					

[14] Where available

2.7 Reproductive Health

Facilities, interventions, services provided	HHP	PHCU	PHCC	CH	CHD
IEC					
Education on sexual health					
Referral to higher health service					
Antenatal Care					
Identification and referral of pregnant women in the community to PCHU/C for ANC					
Clinical examination and search for danger signs					
Early detection and timely referral to either PHCC or County Hospital of danger signs in pregnancies and obstetric complications	(TBA)				
Administration of Tetanus Toxoid, Albendazole, Ferrous sulphate and Folic acid, IPT					
Syphilis and urine test					
VCT and, if indicated, PMTCT					
Management of complications					
Delivery Care					
Normal deliveries					
Timely referral of obstetric complications					
Non-surgical management of obstetric complications and post-abortion care (basic EmOC)					
Surgical management of obstetric complications and post-abortion care (comprehensive EmOC)					
Safe blood transfusion					
Family Planning[15]					
IEC					
Distribution / social marketing of condoms					
Oral contraceptives					
Depot injections					
IUDs					
Surgical contraception					

[15] Some Faith Based Organizations whose mandate doesn't allow the provision of family planning might enter into agreements (consortia, sub-contracting etc.) with separate partners for the provision of this component of the BPHS.

2.8 Child Health and Immunisation

Facilities, interventions, services provided	HHP	PHCU	PHCC	CH	CHD
EPI					
Promoting EPI services among the population and mobilising it for campaigns					
Outreach vaccination					
Outreach vaccination in static facilities					
Fixed vaccination					
Organisation of routine vaccination and campaigns					
Training and supervising					
Requesting, storing and distributing vaccines and other material					
Identification and registration of target population					
IMCI					
Treatment and guidance for children with diarrhoea, ARI and fever (only where IECHC is implemented)					
Treatment of children with diarrhoea, malaria, ARI, anaemia and malnutrition with oral drugs, based on IMCI algorithm					
Treatment of children with injectable drugs and IV fluids based on IMCI algorithm					
Treatment of severely ill children referred from PHCU/Cs					
Safe blood transfusion					

2.9 Communicable Diseases

Facilities, interventions, services provided	HHP	PHCU	PHCC	CH	CHD
General measures					
IEC and preventive measures					
Epidemiological surveillance					
Organisation of mass treatment					
Supervision of case management					
Malaria					
Distribution / social marketing of ITNs					
Clinical case management					
Case management with rapid test diagnosis					
Diagnosis with blood smear					
Case management of severe/complicated cases					
Tuberculosis					
BCG vaccination					
Active case detection and referral					
Identification of TB suspects and referral to PHCC and CH for laboratory diagnosis (AFS)					
Laboratory diagnosis (AFS)					
Clinical management (free DOTS)					
Diagnosis of extra-pulmonary TB					
X-ray investigation (usually in state hospital)					
HIV/AIDS					
ABC promotion and condom distribution					
Passive case detection and referral					
Home based care					
Cotrimoxazole Prophylactic Treatment (CPT) and Multivitamins					
Treatment of opportunistic infections					
VCT and PMTCT					
Screening of blood and blood products					
Others, especially 'forgotten diseases' and diseases with epidemic potential					
According to national protocols (early diagnosis and treatment/containment, mass treatment)					

2.10. Nutrition

Facilities, interventions, services provided	HHP	PHCU	PHCC	CH	CHD
Prevention					
IEC on nutrition (especially breastfeeding and weaning practices)					
Growth monitoring of children < 24 months					
Vit A to all children below two as part of EPI					
Iron Sulphate and Folic Acid to all pregnant and lactating women					
Mass antihelminthic treatment (where prevalence of hook worms >20%)					
Diagnosis					
Diagnosis moderate acute malnutrition					
Diagnosis severe acute malnutrition					
Treatment					
Treatment of patients with severe anaemia					
Home treatment for moderate acute malnutrition					
Stabilisation care for severe acute malnutrition					
Follow-up home treatment moderate and severe acute malnutrition					
Laboratory diagnosis of anaemia					
Blood transfusion for severe anaemia					
Others					
Nutritional surveillance					

2.11 Water and sanitation.

Facilities, interventions, services provided	HHP	PHCU	PHCC	CH	CHD
IEC on environmental health, safe drinking water, personal hygiene					
Social marketing of devices for water chlorination (Water Guard)					
Storage of safe drinking water					
Borehole					
Latrine(s)					
Covered pit for waste water disposal					
Hazardous waste management					
Safety boxes					
Fenced-in hole for burning solid waste and safety boxes					
Incinerator (exceptionally)					